

Bright Spots

... in primary care

A High-Performing Teaching Practice: Site Visit to Oregon Health & Science University's (OHSU) Family Medicine Clinic at Gabriel Park

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Site Profile

Name: OHSU Family Medicine Clinic
at Gabriel Park

Location: Portland, Oregon

Type of Practice: Resident teaching
clinic

Payment Model: Fee-for-service

Electronic Health Record: EPIC

General information

Gabriel Park, in a Portland suburb, is one of 4 family medicine teaching sites. Each site has approximately 12 residents. Residents stay at their site during their entire 4-year residency. The clinic cares for 13,000 patients, 70% commercial, 20% Medicare, 10% Medicaid.

Each of the OHSU family medicine teaching clinics has a core faculty (called a focused faculty), who on average see their patients 4-5 half-day sessions per week plus 2 sessions precepting. Full-time faculty generally start at 8 half-day clinic sessions, but over time some reduce their clinic time to take on more academic responsibilities. NPs/PAs are considered faculty and many work 6-8 sessions per week.

As a result of 1) a focused faculty and 2) only a small number of residents at each clinic, the great majority of patient visits are with faculty providers rather than residents. Thus residents play less of a role in patient scheduling and team structure, allowing for a better organized clinic compared with teaching clinics more dependent on residents as primary care providers. The faculty, including NP/PAs, are the clinical glue.

Take Away Messages

- The OHSU family medicine program has made its primary care clinics “resident-proof” by (1) having a focused faculty who care for most patients, and (2) assigning residents to one of the four clinics during their entire residency, which means that each clinic does not have to juggle the schedules of large numbers of residents.
- The OHSU model should be considered by residency programs with large, resident-heavy teaching clinics.

Engaged leadership

Ann Tseng is medical director and Roger Garvin is residency director. The clinic executive team includes Dr. Tseng, who sees patients at the clinic, the practice manager, a clinical supervisor, the lead RN, and front and back office leads. The administrative site for the residency is on the main OHSU campus (“the Hill”), far from any of the teaching clinics. The residency leadership team includes the program director and 10 associate residency program directors. A practice transformation coordinator works across all 4 clinics.

The overall goal of the residency is “for resident physicians to become compassionate, competent clinicians and partners who provide patient centered, team based care in all primary care settings.” A 4-page list details objectives in the domains of patient care, medical knowledge, systems-based practice, practice-based learning and improvement, professionalism, and communication. Gabriel Park has developed ground rules: to treat each other with respect and work with each other cooperatively. To engage the entire clinic staff, faculty and residents, in 2015 the Gabriel Park clinic leadership asked everyone to agree upon three words to describe the clinic. The chosen words: “trustworthy, compassionate, and professional” compose the “vibe” of the clinic – words used in interactions with patients and each other.

Scheduling

At the time of the site visit, the residency did not utilize a block scheduling model, for example 4+1 or 2+2 (separating in-patient from ambulatory rotations). Rather, residents come to primary care clinic almost every week during their 4 years, but come more often as R3/4s than as R1s. At a recent summit, the program decided to switch to a 2+2 block model starting in 2017-8.

Faculty scheduling. In the past, faculty chose the number of sessions they would be in clinic and their favorite days to be in the clinic, resulting in faculty availability not tied to patient needs. Some days 10 faculty were in clinic, other days 2. This did not work for patient demand, space, or stable teams and Gabriel Park’s leadership made a dramatic change. Faculty are “level loaded” so that the same number of faculty work in clinic each half-day session, typically 2-3 providers on each team. As a result, teams have begun to work well and physicians work with the same support staff almost every day. To make this change, the clinic leadership started with faculty who were flexible with their schedules, and those faculty helped bring on board the entire faculty. Faculty generally are paid more for clinic work than for other academic activities; faculty compensation is RVU-based, creating an incentive to work more clinic sessions and see more patients.

Faculty are discouraged from working fewer than three clinic sessions per week, though there are some exceptions (e.g. the residency director and department chair). As a result, a focused faculty has emerged that spends much of its time at Gabriel Park and is responsible for most patient visits and resident precepting. Vacations need to be requested 60 days in advance. Faculty templates (days the faculty is seeing patients) are open for the entire year, allowing the clinic front desk to know when each faculty member (physicians, NPs, and PAs) is available for patient appointments.

Resident scheduling is less well-developed, though the new 2+2 block model may change that. The residency staff on “the Hill” interact with each clinic-based administrative coordinator. Having the schedulers in separate locations makes communication somewhat more difficult. Gabriel Park receives resident schedules 2-3 months in advance; the clinic’s goal is to get a full-year schedule. After receiving residents’ schedules, the clinic administrative coordinator sends them to the MA and front desk leads so that staff and patients can be scheduled.

Resident clinic schedules are negotiated with the leadership of the in-patient medical service, ICU, ED, OB, other specialty services, and didactic time. For some services, family medicine residents are not crucial to their coverage so they do not care which day the resident goes to clinic. For other services, residents are crucial to their coverage and those services tend to dictate residents’ clinic time. Some services accept the need for residents to have one clinic half-day; others are less understanding, so scheduling negotiations vary with the service. The new 2+2 block model will change this process.

Two issues are 1) how soon the clinic gets the residents’ schedules from other services, and 2) whether each resident could come to the clinic on the same half-days throughout the year, allowing more stable teams. If there are 8 residents in clinic on Tuesday afternoons and 1 resident on Thursday afternoons, some residents are forced to switch teams, which means that they don’t have a sense of their clinic team as their family.

Because of the difficult scheduling issues, residents at times find the clinic a burden rather than a comfortable place to see patients. The 2+2 block model may solve this problem.

Data-driven improvement

The data team for the entire residency drills metrics down to the provider/team level. At Gabriel Park, the data is discussed every month and the MA of the provider with the best performance gets a prize (MAs have a lot to do with performance). Some Gabriel Park September 2016 metrics are:

- Mammography: 72%
- A1c under 8: 76.4%
- Blood pressure in control: 73%
- Continuity: % visits with faculty PCP: 63.5%
- Patient satisfaction: 95%

A survey assessing clinician and staff engagement found some burnout, more for front office, less for back office. High scores were recorded for “I enjoy working at Gabriel Park”, “I am proud to work at Gabriel Park,” and “When needed I will put in extra effort to get a job done.”

Empanelment

Average faculty panel size is 150 per 0.1 FTE (750 for half-time). R1s have at least 50 patients, R2s at least 200, R3s at least 250, and R4s 350-400. The clinic balances panels so that R1s have men, women, kids, at least 5 patients with diabetes and 5 with hypertension. NP/PAs are empaneled, with 1000 patients per 1.0 FTE on average.

Teams

Team structure. Gabriel Park has 3 primary care teams – Blue, Red, and Green, plus a sports medicine Purple Team. Each team consists of 4 – 7 faculty physicians, 1 NP/PA, about 4 residents, one RN, and 3-4 MAs. There is an attempt to make the teams visible to patients; some patients know their team and others do not.

Keeping the teams stable (team members always work on their team and patients always see their team) is a challenge as with all teaching clinics; on some days there may be – for example -- 1 clinician on Red Team, 4 on Blue Team, and 5 on Green Team, requiring staff to work on a non-home team. This variation is largely due to resident schedules, as faculty are level-loaded by clinic sessions. When the teams were developed, faculty physicians were paired with a consistent MA; every effort was made to preserve longstanding faculty/MA relationships. Residents are also paired with a one MA but due to variability in their schedules, faculty/MA pairings trump resident pairings.

The clinic co-located its teams January 2016. The architecture was not altered, but the seating arrangements were changed so that physician/MA dyads sit together as much as possible. Precepting is done in a separate room.

Faculty see 8 – 8.5 patients per session, NP/PAs 7.5. Gabriel Park decided to make visits 20 minutes, with 40 minutes for annual exams and procedures. Other OHSU clinics use a 15/30 minute rather than 20/40 minute template.

Team roles. MAs, in the rooming workflow, identify health maintenance care gaps, can pend orders to close those gaps, and perform a number of well-child tasks. MAs do not act as scribes, though this function has been discussed. An eventual goal is 2 MAs per physician to allow for enhanced roles. Co-location allows MAs to have 15-second huddles after rooming patients to alert the physician to any issues that arose in the MA's pre-visit.

The extent to which MAs are empowered to extend their scope of practice depends on the relationship between the MA and the physician working with that MA. One MA described that he has worked with the same physician for 5 years and knows the physician's entire panel of patients. Over time, the physician allowed the MA to take more and more responsibility; for example, immunizations by protocol, pending medication refills, and routine chronic and preventive care orders – without having to consult the physician. Long-term provider/MA relationships creates trust and encourages more MA responsibility. Bottom line: MA scope of work depends on the degree of trust the physician has in the MA and the length of time they have worked together.

RNs, one per team, focus much of their time as care managers for the team's high-needs, high-cost patients with RN visits, pre- or post-visits before or after a physician visit, and phone calls. Care manager RNs also check the discharge list from the hospital each morning, call patients within 72 hours of discharge, and arrange for them to be seen within one week. The care management RNs meet once a week to problem-solve and standardize their work. RNs experience some burnout, describing their work as "pulling the same people out of the river every day."

To free up RN time for care management, LPNs have assumed the triage function. They forward problems they cannot handle to the team RN. RNs directly take triage calls from their high-needs, high-cost patients. RNs do not have standing orders to adjust most medications nor to independently authorize refills.

Behavioral health consultants receive warm hand-offs from clinicians and schedule office visits and phone follow-ups. Two referral coordinators arrange referrals for patients both inside and outside the OHSU system.

Continuity of care

If their PCP is not in clinic, patients sees someone else on the team who has access. Team continuity (with 4-5 people) is over 80%; individual continuity is 60% for faculty and more variable for residents. On heavy inpatient rotations, resident continuity is very low, but on clinic rotations, continuity matches that of faculty. One chief resident explained that he always works on the Red Team and if not in clinic, his patients are seen by the team PA or one faculty member – continuity with 3 providers.

Access

The clinic's goal is a third next available appointment (TNAA) under 7 days for new and established patients and to start the day with 30 slots open. At the time of the site visit, access was down and the clinic will add 3 faculty providers to improve access. The clinic generally fills 50% of its appointment slots in advance; 30% open 7 days prior to the appointment and 20% open the morning of the appointment. The leadership team reviews third next available appointment metrics weekly.

Summary

During this brief visit it was not possible to address all the Building Blocks of high-performing teaching clinics. We focused mainly on scheduling and teams.

The OHSU family medicine residency program has important lessons to teach other primary care residency programs. Most important, the program has to a large extent made its primary care clinics "resident-proof," meaning that the clinic does not depend heavily on residents for its patient care. This is accomplished by 1) having a focused faculty who care for most patients, and 2) assigning residents to one of the four clinics during their entire residency, which means that each clinic does not have to juggle the schedules of large numbers of residents. This model contrasts sharply with some resident clinics in which all residents in a program (sometimes 30 or 40) work in one clinic and a large proportion of patient

visits are visits to residents. These large, resident-heavy clinics are much more difficult to organize because they are so dependent on residents' schedules. The OHSU model should be considered by residency programs with large, resident-heavy teaching clinics.

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